

Request for Review by Physician Panel
Energy Employees Occupational Illness
Compensation Program Act (EEOICPA)
Part D DOE State Workers' Compensation
Assistance Program

U.S. Department of Energy
Office of Environment, Safety and Health
Office of Worker Advocacy

EMPLOYEE APPLICATION

For assistance in completing this application, please refer to the attached Instructions for Completing the Request for Review by Physician Panels -- Employment Application. **DO NOT FILL IN SHADED AREAS**

EMPLOYEE INFORMATION

Official Use Only. To be completed by HQ or RC
OWA _____ DOL _____

1. Name _____
Last First M.I.

Former Name (i.e., maiden name/legal name change/other)

2. Address _____

3. Telephone (Day) _____ (Evening) _____

4. E mail Address (optional) _____

5. Social Security Number _____ - _____ - _____

6. DOB ____/____/____

7. Are you a: Current DOE contractor Former DOE contractor DOE contractor retiree

EMPLOYMENT INFORMATION

8. Please complete and attach the DOE Employment History for Claim Under Energy Employees Occupational Illness Compensation Program Act (DOE Form 350.6).

The DOE Work History Form has been completed and attached

ILLNESS INFORMATION

9. What diagnosed illness (es) do you have that you believe to be caused by your work at a DOE facility(s)? **If necessary, use additional sheets of paper.**

Illness

Date of Diagnosis

10. Physician/clinic that diagnosed your illness. (An *Authorization of Release Information* DOE Form 350.4 must be completed and attached.) **If necessary use additional sheets of paper.**

Name of Physician
or Health Care Provider

Address:

Phone No:

_____	_____	_____
_____	_____	_____
_____	_____	_____

An Authorization for Release of Information has been completed and attached for each physician or healthcare provider listed.

11. Have you received a medical screening through a DOE-sponsored Former Worker Program (like PACE or CPWR), please check the appropriate program. No, I did not participate in a Former Worker Screening Program.

Amchitka Workers Medical Surveillance
Hanford Building Trades Medical Surveillance
University of Washington Former Hanford Workers
INEEL, Medical Screening Program
Iowa Army Ammunition Plant Former Workers
Los Alamos National Lab Former Workers
Nevada Test Site Former Worker Program
Oak Ridge Former Construction Worker Medical Surveillance
Oak Ridge K-25 Production Worker Medical Screening Program
Paducah Medical Screening Program
Portsmouth Medical Screening Program
Rocky Flats Former Worker Program
Augusta Building Trades Medical Surveillance Program
Savannah River Production Former Workers Program

ADDITIONAL INFORMATION

12. Have you filed a claim under the Department of Labor Federal program for any of the following?

Beryllium Disease

Cancer (type of cancer _____)

Silicosis

Other: _____

No, I have not filed a claim under the Department of Labor (DOL) Federal program.

If yes, what is the DOL claim number? _____

13. Have you filed a State Workers' compensation claim for any illness listed in #9 above: Yes No

Illness: _____

State: _____

Outcome: accepted denied pending

Date filed: _____

14. We are providing here an opportunity for you to authorize the Office of Worker Advocacy staff to discuss your claim with individuals you wish to name. To maintain the confidentiality of your case, if you wish to allow an individual to contact the OWA on your behalf, please identify them by name below and, for identification purposes, list the maiden name of the individual's mother.

_____	_____	_____
Last	First	Mother's maiden name

_____	_____	_____
Last	First	Mother's maiden name

CLAIMANT DECLARATION

I hereby make a claim for assistance under Part D of the Energy Employees Occupational Illness Compensation Program Act and affirm that the information I have provided on this form is true. I understand disclosure of this information is voluntary, but failure to provide necessary information may involve delay in processing my claim or may result in a denial of my claim.

The information submitted is authorized to be collected by the Department of Energy, Office of Worker Advocacy, by the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) of 2000. The principal purpose for which these records are to be used is to help determine my eligibility for benefits under the EEOICPA by verifying medical condition(s) or exposure(s) to radiological or toxic substances during an employment time period that is covered under the EEOICPA. Other uses which may be made of this information are the following: the employment verification, medical, exposure and other additional records may be retained in my claims file and may be released to any person whose responsibilities include processing of my claim .

I hereby attest that the records, copies of records and or other information I have submitted to the Department of Energy, Office of Worker Advocacy are authentic. I further attest that these records have not been altered, and no materials have been removed from these records.

Furthermore, I authorize any physician or hospital or any other institution, corporation, or government agency to furnish any desired information to the U.S. Department of Energy, Office of Worker Advocacy.

I understand that any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain assistance by the Department of Energy, Office of Worker Advocacy, or who knowingly accepts assistance to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Claimant Signature

Date

INSTRUCTIONS
FOR COMPLETING THE REQUEST FOR REVIEW BY PHYSICIAN PANEL, ENERGY EMPLOYEES
OCCUPATIONAL ILLNESS COMPENSATION PROGRAM ACT
(EEOICPA)- **EMPLOYEE APPLICATION**

The following instructions are provided to assist you in completing the **Request for Review by Physician Panel Employee Application**. Please complete this form to the best of your ability. Any omission of information could cause a delay in the review of your claim. A signature is required to submit your claim.

OMB Burden Disclosure Statement

Public reporting burden for this collection of information is estimated to average 1 hour 13 minutes, including time for reviewing instructions, searching existing data sources, gathering data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Records and Business Management (IM-11), U.S. Department of Energy (OMB 1910-5120), Washington, D.C. 20585 and to the Office of Management and Budget (OMB), Paperwork Reduction Project (OMB 1910-5120), Washington, D.C. 20502. **Do not mail your application to this address, see section Claimant Declaration for mailing address.**

Employee Information

1. Fill in your name (last, first, middle initial). If you have used any other name, please include that on the space provided.
2. Provide your complete address.
3. Provide a telephone number where you can be reached during both day and evening hours.
4. Provide Email address if applicable.
5. Provide your Social Security Number.
6. Provide your date of birth.
7. Indicate if you are a current DOE contract employee, former DOE contractor or retiree of a DOE contractor.

Employment Information

8. Complete the Department of Energy Work History Form (DOE Form 350.6) and check the box to indicate you have filled out and attached the DOL Employment History form.

Illness Information

9. Please list the diagnosed illness that you believe to be a result of your work at a DOE facility and the date of the diagnosis. If there are multiple illnesses, please list the information on an additional sheet of paper and attach to this request.

10. List all physicians or healthcare providers with their respective addresses and phone numbers who diagnosed or treated the illness(es). Use extra pages if needed.
- Note: You must complete, sign, and attach an *Authorization for Release of Information* (DOE Form 350.4) for each physician or healthcare provider listed, so that the Office of Worker Advocacy can obtain records relevant to your application. You must also fill out this form if you participated in a Former Worker Program or applied to the Department of Labor. The signature must be original; photocopies will not be accepted.
11. If you have received a medical screening through a DOE-sponsored Former Worker Program (FWP), check the appropriate box(es) of the FWP in which you participated.

Additional Information

12. If you have filed a claim for Federal compensation with the Department of Labor, please check the appropriate box. If you submitted a claim for a disease/illness other than Beryllium Disease, Cancer, or Silicosis, please check the "Other" box and write in the disease/illness for which you submitted a claim. If you have filed a DOL claim, fill in the DOL claim number if you know it.
13. Mark the appropriate box. If you have filed a State workers' compensation claim for an illness that you have listed in #9, please indicate the illness, the State in which you filed the claim, the outcome, and the date the claim was filed.
15. To protect your confidentiality, the office of Worker Advocacy will not discuss your file unless the applicant or primary survivor gives the Office permission. Therefore, please list all individuals and their relationship to you whom you authorize to discuss your claim with OWA.

Claimant Declaration

An original signature and date is required for this claim to be reviewed. Please submit your claim through your local resource center or send to the following address:

U.S. Department of Energy
Office of Environment, Safety and Health
Office of Worker Advocacy, EH-8
L'Enfant Plaza, Suite 800
1000 Independence Avenue, SW.
Washington, DC 20585

Attn: Claims Processing/application

If have questions, contact your local Resource Center or call 1-877-447-9756.

Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) The Energy Employees Occupational Illness Compensation Program Act-Part D (P.L. 106-398) (EEOICPA) authorizes the collection of the information on this form; (2) The Office of Worker Advocacy of the U.S. Department of Energy, which administers the program, may disclose information to Federal agencies or private entities which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider other relevant matters; this is the principal purpose for which this information is collected; (3) information may be disclosed to federal agencies or entities whose mission entails reviewing or managing workers' compensation claims or administering other benefits programs; (4) information may be disclosed, as a routine use, to physicians and other health care providers for use in providing treatment or medical rehabilitation, making evaluations for the Office of Worker Advocacy, and for other purposes related to the medical management of the claim; (5) furnishing this information is voluntary, but failure to disclose all requested information may delay the processing of the claim or may result in an unfavorable decision. This notice applies to all forms requesting information that you might receive from the Office of Worker Advocacy in connection with the processing and adjudication of the claim you filed under the EEIOCPA.